

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION:**

**SOAH DOCKET NO. 453-04-5929.M5**

MDR Tracking Number: M5-04-0210-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 9-17-03.

The IRO reviewed electrical stimulation, diathermy, joint mobilization, myofascial release, office visits, group therapy, therapeutic exercises, ROM, physical performance testing, muscle testing, special supplies, special reports, mechanical traction and massage from 9-17-02 through 6-18-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO concluded that the electrical stimulation, diathermy, joint mobilization, myofascial release, office visits, group therapy, therapeutic exercises, ROM, physical performance testing, muscle testing, supplies, special reports, and massage from 9-17-02 through 10-30-02 **were** medically necessary. The IRO agreed with the carrier's previous decision that electrical stimulation, diathermy, joint mobilization, myofascial release, office visits, group therapy, therapeutic exercises, ROM, physical performance testing, muscle testing, supplies, special reports, mechanical traction and massage after 10-30-02 through 6-18-03 **were not** medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 11-25-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

Dates of service with no EOB will be reviewed per the 1996 *Medical Fee Guideline*.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR\$ (Max. Allowable Reimbursement)	Reference	Rationale
9-30-02	95851 3 units	\$40.00 ea unit	\$0.00	G	\$36.00	Rule 133.307(g)	ROM testing is not global.
11/6/02	95851 1 unit			F, TK F, TK		(3) (A-F) and Rule 133.1	Relevant and legible information supports delivery of service. Recommend reimbursement of \$36.00 x 9 units = \$324.00.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
11/11/02  1/23/03	95851 2 units  95851 3 units			F No EOB			
10/11/02 10/14/02	97150	\$27.00 ea DOS	\$0.00	F F	\$27.00	Rule 133.307(g) (3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$27.00 x 2 = \$54.00.
10/21/02	97265 97250 97110 97150	\$43.00 \$43.00 \$140.00 \$27.00	\$0.00 \$0.00 \$0.00 \$0.00	No EOB	\$43.00 \$43.00 \$35.00 ea 15 min \$27.00		97265, 97250, 97150. Relevant information supports delivery of service. Recommend reimbursement of \$43.00, \$43.00, \$27.00 = \$113.00. 97110. See RATIONALE below.
10/23/02	97110	\$210.00	\$35.00	No EOB	\$35.00 ea 15 min		See RATIONALE below. No reimbursement recommended.
10/25/02	97110	\$245.00	\$35.00	No EOB	\$35.00 ea 15 min		See RATIONALE below. No reimbursement recommended.
10/30/02	97265 97250 97110 97150	\$43.00 \$43.00 \$210.00 \$27.00	\$0.00 \$0.00 \$0.00 \$0.00	No EOB	\$43.00 \$43.00 \$35.00 ea 15 min \$27.00		97265, 97250, 97150. Relevant information supports delivery of service. Recommend reimbursement of \$43.00, \$43.00, \$27.00 = \$113.00. 97110. See RATIONALE below.
9-17-02 9-19-02 9-20-02 9-23-02 9-24-02 9-26-02 10-9-02 10/11/02 10/14/02	99213	\$50.00 x 9	\$0.00	F	\$48.00	Rule 133.1	Relevant information supports delivery of service for all dates of service except 9-19-02 and 9-26-02. Recommend reimbursement of \$48.00 x 7 = \$336.00.
10/23/02 10/30/02 11/1/02	99213	\$50.00 ea DOS	\$0.00	No EOB	\$48.00		Relevant information supports delivery of service. Recommend reimbursement of \$48.00 x 3 = \$144.00.
11/6/02 11/8/02	99214 99213	\$75.00 \$50.00	\$0.00	F, TK	\$71.00 \$48.00		Legible and relevant information supports delivery of service. Recommend reimbursement of \$71.00 + \$48.00 = \$119.00.
1/13/03	97265 97250 97110 97150	\$43.00 \$43.00 \$175.00 \$27.00	\$0.00 \$0.00 \$0.00 \$0.00	No EOB	\$43.00 \$43.00 \$35.00 ea 15 min \$27.00		Requestor failed to submit relevant information to support delivery of services. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
1/23/03	99215	\$125.00	\$0.00	No EOB	\$103.00		Relevant information supports delivery of service. Recommend reimbursement of \$103.00
3/19/03 3/20/03	99213 99214	\$50.00 \$75.00	\$0.00	O	\$48.00 \$71.00		Requestor failed to submit relevant information to support delivery of services. No reimbursement recommended.
11/6/02 5/21/03 6/6/03 3/20/03	99080-73 ea DOS	\$15.00	\$0.00	F, TK F F O	\$15.00		Rule 129.5, 133.307(g) (3) (A-F). 133.1 Requestor failed to submit relevant information to support delivery of services. No reimbursement recommended.
1/9/03	97265	\$43.00	\$0.00	No EOB	\$43.00		Relevant information supports delivery of service. Recommend reimbursement of \$43.00.
1/29/03	97150	\$27.00	\$0.00	No EOB	\$27.00	Rule 133.307(g) (3) (A-F)	Requestor failed to submit relevant information to support delivery of services. No reimbursement recommended.
12/5/02 1/23/03	97750 MT 3 units 97750 MT 5 units	\$129.00 \$215.00	\$0.00	G  No EOB	\$43.00 per body area		Muscle testing is not global. Relevant information supports delivery of service. Recommend reimbursement of \$129.00 + \$215.00 = \$344.00.
3/13/03	97014	\$17.00	\$0.00	O	\$14.00		Relevant information support delivery of service. Recommend reimbursement of \$14.00.
6/9/03	97014	\$17.00	\$0.00	No EOB	\$14.00		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
3/17/03 3/18/03 3/19/03 6/18/03	97110 97110 97110 97110	\$140.00 \$175.00 \$280.00 \$70.00	\$0.00	O O O D	\$35.00 ea 15 min		See RATIONALE below. No reimbursement recommended.
3/18/03 6/18/03	99080 143 pgs 99080 288 pgs	\$71.50 \$144.00	\$0.00	O  D	\$.50 per page		Relevant information support delivery of service. Recommend reimbursement of \$71.50 + \$144.00 = \$215.50.
6/17/03	97024 97014 97012	\$25.00 \$17.00 \$20.00	\$0.00	D	\$21.00 \$15.00 \$20.00		Relevant information supports delivery of services. Recommend reimbursement of \$21.00, \$15.00, \$20.00 = \$56.00.
TOTAL		\$4,016.50	\$70.00				

**RATIONALE:** Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the relevant information did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

The above Findings and Decision are hereby issued this 9<sup>th</sup> day of April 2004.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

### **ORDER**

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 9-17-02 through 6-18-03 in this dispute.

This Order is hereby issued this 9<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

### **IRO Certificate #4599**

### **NOTICE OF INDEPENDENT REVIEW DECISION** amended 3/29/04

November 21, 2003

**Re: IRO Case # M5-04-0210-01**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC).

Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received

an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_\_ for an independent review. \_\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to \_\_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

#### History

The patient injured his neck, lower back, left shoulder and left knee in \_\_\_\_ when he fell off the back of a delivery truck, landing on his back, with a "work surface" then falling on top of him.. He was taken to the ER, given medication, x-rayed, and taken off work. He then presented to the treating D.C. He has been treated with chiropractic treatment, TPIs, lumbar ESIs, medication and physical therapy. He has also been evaluated with MRI and EMG.

#### Requested Service(s)

Electrical stimulation, diathermy, joint mobilization, myofascial release, office visit, group therapy, therapeutic exercises, ROM measurements, physical performance testing, special supplies, muscle testing, initial medical report, special reports, massage therapy, mechanical traction 9/17/02-6/18/03

#### Decision

I disagree with the carrier's decision to deny the requested treatment through 10/30/02.

I agree with the denial of the requested treatment after 10/30/02 through 6/18/03.

#### Rational

The patient received extensive chiropractic treatment from the treating D.C. without documented relief of symptoms or improved function. According to the records provided for this review, the patient actually deteriorated during the treatment period. He was

initially diagnosed with sprain/strain injuries to the cervical spine, thoracic spine. Lumbar spine and left knee. The patient had also described an injury to his groin two weeks prior to the recent injury. In a 10/23/02 report it was noted that the patient's over all pain scale

was never greater than 5/10. He denied any feelings of hopelessness or guilt, and his motivation was fine. Several months later, the same doctor reported that the patient was depressed, his pain scale often reached 9/10, he developed a loss of bladder control, and was functionally impaired and socially isolated. These were indications that treatment was failing, yet treatment continued for several more months with poor results. The initial lumbar spine report on 10/8/02 revealed only a broad-based disk bulge at L4-5, without evidence of nerve root compression, spinal stenosis, cord lesion or cauda equina lesion. The neural foramina were widely patent. The cervical spine MRI was essentially negative, and x-rays were also unremarkable. The patient basically had soft tissue injuries and a bone contusion of the left knee that should have responded well to conservative treatment within 6-12 weeks. Based on the documentation presented, the patient failed to respond to treatment after 10/30/02. Continued use of failed non-effective therapy is not medically necessary. Treatment past 10/30/02 was over-utilized and inappropriate, because the patient's condition was declining. At that time he should have been put under the care of a neurologist or neurosurgeon. The records do not explain why chiropractic treatment continued for several months as the patient's condition continued to deteriorate. An initial trial of chiropractic treatment through 10/30/02 was appropriate for a sprain/strain injury. The records do not show why treatment past that date was medically necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.